The Young Offender Initiative: Reentry Grant Program Background and Current Reentry Efforts for Persons with Mental Health Disorders

Background

Adult Offenders Returning to the Community

Nearly 600,000 State and Federal offenders returned to the community in 2000 (Beck, 2000). Added to this figure are millions of detainees released from jail during the year. Of the many released inmates, a large number return to custody. Prison growth is largely propelled by admissions resulting from parole violations, which constitute approximately 34 percent of all prison admissions. Less than half of parolees successfully completed their terms in 1996. (Travis, 2000). The situation is similar for those released from jails. A large proportion continues to cycle in and out of the jail system. Clearly, the goals of community reentry are not being realized when released inmates return to prisons or jails.

An issue of growing attention is that a significant proportion of individuals released from prison has a serious mental illness. Recent statistics indicate that 14.4 percent of reentering inmates are identified as having a mental illness (Beck, 2000). Around 11 percent have co-occurring substance abuse and mental health disorders (Beck, 2000). Evidence of the reality and persistence of these high rates of disability is demonstrated in the proportion of persons with mental disabilities entering Social Security disability and SSI roles following their return to the community.

Offenders with mental health disorders are at an elevated risk for returning to the criminal justice system if their psychiatric and social needs are not addressed following release from custody. They may be re-arrested because of behaviors that result from their deteriorated psychiatric condition and use of drugs or alcohol or because without adequate housing and rehabilitation skills they are back on the street committing 'crimes of survival'.

Released offenders with mental illness face a range of other obstacles in establishing full and productive lives in communities. Historical employment rates for individuals with mental health disorders are reported to be upwards of 85 percent. Moreover, persons with serious mental illness are over-represented in homeless populations; roughly one-third of homeless persons have a mental illness (Interagency Council on the Homeless, 1994). Approximately one-half of homeless persons have a substance use disorder (Federal Task Force on Homelessness and Severe Mental Illness, 1992). The burden of stigma has kept many persons from seeking mental health care. When care has been sought, it has often been unavailable. Community integration becomes even harder to achieve when offender status is added to these obstacles.

Despite these obstacles, there is a chance that the destructive cycle of arrest, release, deterioration, negative social outcomes, and re-arrest can be slowed if individuals receive proper and continuous psychiatric treatment and medications. For mental health services delivery, there now exist demonstrably effective treatment and support services. As

detailed in *Mental Health: A Report of the Surgeon General* (U.S. Department of Health and Human Services, 1999), there have been broad advances in the use of several types of treatment interventions. Modern medications such as the SSRI anti-depressants can reduce symptoms dramatically. With proper management, the most debilitating side effects of treatment with medication can be reduced or eliminated. Furthermore, several types of interpersonal therapies, notably cognitive-behavioral therapy and group treatment modalities have solid evidence bases for their effectiveness and are often used in combination with medication.

A number of additional approaches have proven effective in providing structure and supports that individuals need to function productively in the community and establish strong and lasting relationships with family and friends. Supported employment interventions and education are effective in helping persons obtain and maintain employment as a member of the competitive workforce. Supported housing services help persons with mental illness to live safely in independent housing, and to avoid the problems often found in group living arrangements. These supports allow individuals to better manage their illness. Available and readily accessible supports have the potential to increase the likelihood that an individual can remain a functioning member of the community over the long-term, especially when coupled with medications and treatment as described above.

Children and Youth Returning to the Community

It is widely held that the trends that affect adults also affect juveniles being released from juvenile detention and correctional facilities. Despite the lack of adequate research on the prevalence and type of mental health disorders affecting youth in the juvenile justice system, general conclusions can be drawn from the data. Youth in the juvenile justice system experience substantially higher rates of mental health disorders than youth in the general population (Otto et al 1992). A high percentage, as many as 80% (Otto, 1992; Wierson, et al 1992; Virginia Policy Design Team, 1994) of youth in the juvenile justice system have a diagnosable mental health disorder. It is estimated that one out of every five youth in the juvenile justice system is experiencing a serious mental health disorder that interferes with their functioning and for whom access to mental health services is critical (Schultz & Mitchell-Timmons, 1995).

Further, many of the youth with mental illness in the juvenile justice system are also experiencing a co-occurring substance abuse disorder. Preliminary data from a baseline study of juvenile detainees in Cook County indicate that two-thirds of the youth have one or more alcohol, drug and mental (ADM) disorders, and that nationally, more than 670,000 youth processed annually in the juvenile justice system would meet the diagnostic criteria for one or more ADM disorders that require mental health and/or substance abuse treatment (Teplin, 2001).

Identifying and responding to the mental health needs of youth with mental health disorders in contact with the juvenile justice system is now being recognized as a critical issue (Cocozza and Skowyra, 2000). At the same time that attention and awareness of this issue has grown, so has the development of promising policies, practices, and research to better understand and respond to these youth. These advancements include:

- The development of tools such as the MAYSI (Grisso and Barnum, 1998), a screening tool used to identify the existence of mental health and substance use disorders among youth in contact with the juvenile justice system.
- The development of effective treatment interventions and approaches for youth with mental health disorders, such as Multi-Systemic Therapy (MST, Henggeler, S. et. al. 1998) and Functional Family Therapy (FFT), which support the assertion that such youth can be treated and managed in community settings.
- The development of the Systems of Care model that provides a community framework for treating children and youth with serious emotional disorders.
- Services such as Family Support and Respite Care, which are designed to help parents fulfill their role as primary care givers for their children in a meaningful way.

Continuity of Care

Simply making available medications, supports and treatment services is not enough to ensure successful transitions from institutions to the community. Successful reentry for adults and youth with mental health disorders requires mechanisms to ensure continuity of care.

There is broad consensus that transitions in care settings represent times of high vulnerability. Continuity of care is especially important for an individual leaving a correctional institution. The inmate may be so acclimated to a highly structured correctional environment that everyday decision-making upon return to the community may be overwhelming. Gains made in treatment inside the institution (as well as outside in the community) may be lost without continuity of care (Barr, 1999; CSAT, 1998).

Continuity of care involves some very simple concepts. It requires that the range of needed services is available for an individual, regardless of the system. While the individual is in care of the correctional system, the institution must provide for their basic care and maintain treatment to the extent possible, acknowledging that in jail settings comprehensive programming often is not feasible given the relatively short length of stay. In addition, the correctional institution must coordinate with community agencies in planning for the inmate's release.

Thoughtful and thorough reentry planning can reduce the incidence of parole violations and subsequent offending, as well as contribute to positive quality of life and treatment outcomes. Careful attention to the mental health problems experienced by returning adults and youth, coupled with aggressive linking to appropriate community-based services can provide significant dividends to communities with strong public safety concerns.

This Appendix will focus on three elements necessary for successful reentry for adults and juveniles with co-occurring mental health and substance use disorders. These encompass:

1) Screening and assessment;
2) Reentry planning; and
3) Systems integration.

Screening and Assessment

An obvious, but essential step in planning treatment for inmates upon release from jails and prisons is identifying mental health and substance use disorders. This is achieved through screening and assessment.

Screening

Screening is a brief process designed to detect the potential presence of mental health and substance use disorders and related problem areas (Peters and Bartoi, 1997). Screening aims to identify "red flags", which warn that an individual may have serious problems and warrants further assessment (McClellan and Dembo, 1993). Methods for screening include the use of structured survey instruments, interviews, and record review.

Until recently, there were very few tools and resources available to assist the juvenile justice system with the identification and diagnosis of mental health and substance abuse disorders among youth involved with the system. While many of the same key principles from the adult system apply to the juvenile system, more work is now being done to develop specific instruments and tools to conduct screening and assessment among these youth, as well as to identify the models and approaches that exist to conduct such screens. Among the most promising tools for conducting mental health and substance abuse screens among youth in contact with the juvenile justice system is the MAYSI II that was developed by Dr. Thomas Grisso of the University of Massachusetts Medical School (Grisso and Barnum, 2000) .

Assessment

Assessment provides a comprehensive examination of psychosocial needs and strengths. Assessments examine the severity of mental health and substance use disorders, conditions associated with disorders, levels of functioning, individual motivation towards treatment, and areas for treatment intervention (Peters and Bartoi, 1997).

Methods for assessment include the use of specialized instruments, interviews, record review, and biological testing for drug and alcohol use. The goals of assessment include the examination of the scope of mental health and substance abuse problems; assessment of the spectrum of psychosocial problems that should be addressed in treatment; and providing a foundation for reentry planning (Peters and Bartoi, 1997).

Key Points Relevant to Screening and Assessment for Reentry

- Universal screening for mental health and substance abuse problems should be conducted at the earliest possible point (i.e. soon after admission), and should be conducted periodically throughout inmates' duration of stay and aftercare. Ongoing screening is essential to detect those individuals who may experience changes in mental health symptoms while incarcerated (Peters and Bartoi, 1997).

- Assessments should be conducted within the institution as early as possible, and also 3 to 6 months before the inmate's release (Committee on Persons with Mental Illness Behind Bars and the Committee on Continuity of Care and Reentry Planning).

- Standardized assessment tools appropriate for inmate populations should be employed across different justice settings.

- Screening and assessment results should follow inmates from the community through the system and back into the community upon release.

- Of critical importance within the juvenile justice system is the need for screening and assessment to be performed throughout a youth's involvement with the system and at key points within the continuum, including before a youth's release from care. Often, an assessment of a youth's mental health and substance abuse service needs can be incorporated into an overall risk assessment to help a juvenile justice facility determine the likelihood of recidivism and the most appropriate community-based placement for the youth.

Reentry Planning

Reentry planning is a collaborative process that results in a set of concrete steps to address the individual's needs and strengths as identified in a comprehensive assessment. The treatment plan should cover care and programming while the adult or juvenile is in the correctional institution, as well as care when the individual is released into the community. Preparing an adult or juvenile for reentry to the community is referred to as reentry planning, release planning or aftercare planning. It involves linking the individual to community services and following up to ensure that they are received. Reentry planning should begin at the time of admission into an adult or juvenile correctional facility or at the time when a psychiatric condition is identified (Committee on Persons with Mental Illness Behind Bars and the Committee on Continuity of Care and Reentry Planning; CSAT, 1998).

In a survey of over a thousand U.S. jails of various sizes, it was found that 26% of the jails reported providing reentry planning services for inmates with mental illness. The researchers estimate the corresponding national weighted figure is 21% of jails (Steadman and Veysey, 1997). The researchers claimed that reentry planning was found to be the weakest of all programs for detainees with mental disorders. During site visits to select jails, researchers observed that although many had programs that offered referrals at release, they were not assertive and included little or no follow-up. Referrals alone do not constitute meaningful treatment/reentry planning. It is not enough to prescribe a plan for an 'about to be released' inmate without facilitating the plan's implementation by creating linkages to community services and supports.

What's in a Reentry Plan?

The reentry plan should be informed by screening and assessment, as well as by records of the individual's participation in treatment and programming inside the facility. The plan must also reflect available community resources. A reentry plan, for an adult or juvenile's return, to the community should be comprehensive and address the constellation of his/her needs. Reentry plans should also incorporate the individual's areas of strengths and supports to be enlisted in the pursuit of treatment goals.

The following areas should be assessed in the development of a reentry plan:

- Psychiatric treatment, including medication
- Substance abuse treatment, including self-help groups
- Physical health treatment
- Housing
- Vocational skills and available employment services
- Transportation
- Family, including dependent children
- Income supports and entitlements (social service, disability, medical, Veterans)

In addition, for juvenile, the following areas should be assessed:

- Education
- Need for alternatives to family reunification
- Child welfare services

It is essential that provisions are made so that the released individual has access to services, supports, benefits, and medications upon release.

Who Develops a Reentry Plan?

A transition team should work collaboratively to develop a reentry plan. Any person who has worked with an individual during incarceration (i.e. nurse, psychiatrist, or vocational counselor) may be able to provide valuable input for the treatment and reentry plan, based on their observations and experience with the individual in a variety of contexts.

It is important that the treatment plan is developed with input from the inmate. Inmates should be present at transition team meetings. They can contribute ideas about what courses of action will work best for them. Participating in the planning can be empowering, and contribute to treatment plan compliance and positive outcomes in the community. No matter the quality of the plan, implementation will not be effective unless the inmate is "on board". In addition, family input in the plan can be informative and important, especially since responsibility of care often shifts to family members when the inmate is released.

In addition to the persons who have worked with the individual inside the facility, and his/her family, the transition team developing the reentry plan ideally includes a case manager who will be responsible for the coordination of community care following

release. The case manager is generally an individual at the primary community agency to which the inmate will be referred for ongoing care, though in some cases parole officers with specialized mental health training take on case management responsibilities and link returning inmates with services prior to their release (Healey, 1999). The case manager should be identified, contacted, and actively involved in the release plan. Efforts should be made to facilitate entry of community service providers into facilities to begin the engagement process prior to release. The inmate prior to release should know a person from the outpatient treatment agency that accepts responsibility for his/her community-based treatment and care (*Position Statement on Post-Release Planning* by the Committee on Persons with Mental Illness Behind Bars and the Committee on Continuity of Care and Reentry Planning of the American Association of Community Psychiatrists).

Implementation of Reentry Plan—The Case Manager

At the heart of effective transitional services is case management (CSAT, 1998). In transition from criminal justice settings, case management is essential for inmates with co-occurring disorders (Hills, 2000). Case management involves the coordination of health and social services in the community for a client, and for offenders, it also involves coordination of criminal justice supervision. Case managers are responsible for maintaining contact with criminal justice officials and sharing treatment information across different parts of the criminal justice system. Ideally, a single case manager works in conjunction with a transition team from all relevant systems. This type of non-traditional case manager serves as a "boundary spanner" (Steadman, 1992).

Inmates with mental illness released from prison or jail are sometimes referred to participation in assertive community treatment (ACT) or intensive case management, as an alternative to the 'brokerage of services' approach to case management. ACT is an effort to integrate major responsibilities for patient care within a single, multidisciplinary, and largely self-contained team (Morrissey, 1999). ACT provides intensive case support services, with case management functions being implemented by a team of professionals who share caseloads and who are on call 24 hours a day. Assertive community treatment may require case managers to seek out the client in his or her home, job, or in the community for meetings, counseling, and to make sure the client is on track. For offenders returning to community, adding criminal justice expertise to the team is critical. Today the mixed model of case management, where the case manager services in a therapeutic capacity and brokers services, is more common than the pure "service broker" model (Healey, 1999).

While more attention is now focused on the identification and treatment of youth with mental health disorders in contact with the juvenile justice system, much less emphasis has been placed on the development of reentry or aftercare initiatives specifically designed for youth with mental health disorders. Far less is known about this as an issue for juveniles than is known for adults, and there is a general lack of research and knowledge about effective reentry planning principles and practice for youth with mental health disorders re-entering the community.

While focused on juvenile justice youth in general and not specifically on youth with mental health disorders, David Altschuler and Troy Armstrong advocate that a successful aftercare or reentry strategy for high-risk youth leaving secure confinement must include:

- Coordinated and comprehensive planning
- Information exchange
- Continuity
- Consistency
- Service referral and provision
- Monitoring (Altschuler, 1994)

One of the few studies conducted on youth with mental health disorders transitioning back to the community underscores what has been suggested from the adults and general juvenile delinquency literature for some time: that youth provided with a structured post release treatment plan do better in the community and recidivate less frequently than youth who do not receive these services. In particular, the study determined that youth who received community mental health services during the period immediately following their release from a state juvenile correctional facility were less likely to re-offend than youth not receiving such services. (Wood et al, 1999).

Systems Integration

Effective arrangements among the criminal justice system, mental health system, and substance abuse system contribute to better outcomes for individuals with co-occurring disorders coming out of jail and prisons. When these systems integrate their functions to provide transitional services, there is enhanced preparation for those inmates who are being released from jail and prisons. The needs of released inmates are better understood and they have a better opportunity to become engaged in appropriate community treatment (CSAT, 1998). In general, systems integration can reduce the duplication of services and administrative functions, thus increasing the amount of resources available to support an individual's reentry into the community.

Systems integration requires the sharing of responsibility, planning, information, and resources. System integration involves new arrangements among the service organizations themselves, including their treatment services, administration, management information systems, assessments and staff training. It does not require the creation of a single system, but does demand an interconnected network of organizations that can complement each other through the transfer of appropriate information, resources and clients among the component units. (Open Society Institute and the National GAINS Center, 1999).

It is important to integrate mental health, substance abuse, and criminal justice systems to overcome the system barriers. Traditionally, there has been resistance among community mental health providers to working with individuals with criminal histories, and in corrections, there is resistance to working with persons with serious mental illness. Efforts should be made to cross train staff from all involved agencies, in order to better understand the other systems' underlying philosophies and practice. In general, effective reentry planning requires an integrated effort across the boundary between the criminal

justice system and the behavioral health system (Committee on Persons with Mental Illness Behind Bars and the Committee on Continuity of Care and Reentry Planning).

In collaborating to provide integrated transitional services, participating agencies and systems should work out agreements which clarify roles and policies. The agreements might include the following (CSAT, 1998):

- The development of a shared "vision statement";
- Goals of transitional services;
- Specific roles, expectations, and responsibilities of each agency;
- Timing of tasks;
- Monitoring and oversight procedures;
- Shared information requirements;
- Client confidentiality; and,
- Evaluation of efforts.

When systems work together to serve individuals whom they view as their mutual responsibility, the individual, the systems and the communities are all bound to benefit.

The development of the Comprehensive Community Mental Health Services for Children and Their Families program illustrates a systems integration model and provides a community framework for treating children and youth with serious emotional disorders. This "System of Care" model weaves mental health and other supports into a coordinated fabric of services to meet the diverse, highly individual and changing health, educational and supportive needs of children and adolescents with severe emotional disturbance (CMHS, 1998). Wraparound Milwaukee is an example of a System of Care model that offers individualized, community-based treatment to youth involved with the juvenile justice system, as well as an array of family supports and services (Kamradt, 2000). Key elements within Wraparound Milwaukee include:

- Strength-based approach to children and families;
- Family involvement in the treatment process;
- Needs-based service planning and delivery;
- Individualized service plans; and
- Outcome-focused approached.
- Innovative Approaches for the Implementation of Reentry Services

Integrated Corrections-Based Multistage Therapeutic Community Treatment for Substance Abuse

Delaware's integrated corrections-based multistage therapeutic community (TC) treatment was initially funded by the National Institute of Justice as a research demonstration project in 1991. The program has evolved into a three-stage model, in which therapeutic community treatment is provided at successive stages of an inmate's trajectory through the prison system into the community. The primary stage of treatment is a prison-based TC unit, segregated from the rest of the prison. The second stage of treatment consists of a transitional TC, a TC work release center. The third stage, or

aftercare stage, involves continued monitoring by TC counselors and outpatient counseling, group therapy, and family session. (Martin, Butzin, Saum, Inciardi, 1999).

Reentry Drug Courts

Reentry drug courts aim to keep offenders engaged in corrections-based treatment while incarcerated, and to follow up with appropriate community treatment once the offender is released in an effort to provide seamless and continuous care. Offender accountability is maintained through continuous court-based monitoring throughout custody and aftercare. (National Drug Court Institute, 1999). There have been initiatives to create both jail-based and prison-based reentry drug courts.

The National Drug Court Institute jail-based treatment focus group has developed the following mission statement: "Reentry drugs courts are courts that begin when the offender enters a jail-based treatment program. The offender is involved in regular judicial monitoring, supported through recovery, and ultimately prepared for reentry into the community. This team-based approach supports jail-based treatment values, monitors accountability, provides rewards and penalties, and prepares the offender for reentry at a community-based drug court program session."

In advance of an inmate's release, reentry drug courts conduct pre-release planning which addresses such issues as sober living, employment and transportation. Arrangements are made for aftercare services for substance abuse treatment, and medical or psychological services as needed. After completing the jail phase of the treatment program, the released inmate is brought to court for a "graduation" and is then accompanied to the community treatment program, as in San Bernardino County, California. (National Drug Court Institute, 1999).

Prison-based reentry drug courts typically require pleas at the front-end of the case. Participants serve a sentence in prison, during which time they participate in treatment. While in prison, the offender is assigned a community case manager who attends periodic status reviews inside the correctional facility and meets with the inmate to build a rapport prior to release. The case manager makes sure services are in on the day of the inmate's release. After completing the prison phase, individuals are required to serve a probationary period in the reentry drug court, which seeks to maintain the structure and stability offered in the prison-based treatment program. The reentry drug court monitors the offender through drug testing, probation/parole visits, and home visits. The community case manager serves continues to work with the individual and provide updates to the drug court. (National Drug Court Institute, 1999).

Innovative Reentry Programs

Many communities have struggled with the development, creation and implementation of reentry programs. Among the following descriptions are programs that differ widely in their approaches. The list is by no means exhaustive of all innovative programs in the U.S.

Colorado Reentry Court Pilot Program

The Colorado Reentry Court Pilot Program is part of the Office of Justice Program's Reentry Courts Initiative to safely and effectively reintegrate offenders into the community. The goal of the initiative is to decrease public risk, increase parolee functioning in the community and decrease the re-incarceration rate.

The Colorado Reentry Court builds on treatment efforts of the TAC program to provide parolees with a bridge between pre-release and the community. This court aims to provide an even higher level case management to those with substance use and/or mental health disorders. The goal is to provide increased case management, effective community reintegration during the parolee's first 12 months post-release. The Court pilot consists of two parts: the Reentry court and a Community-Based Forensic Treatment Program, which provides individualized case management and treatment services for all TAC clients.

Program partners include the Pikes Peak Mental Health Organization, administrative law judges, and parole officers. Under the program, a parolee must meet with an administrative law judge prior to release to establish a "benchmark for success." Through the participation of the judge, parole officer, and case manager, the group outlines a treatment plan and timeline for the offender. This group will also assist the offender by recommending services and to find a job and a place to live and appropriate supports and services.

Due to the fact the target population of the program includes both high and low level offenders and that the program cuts across various agency lines, the Colorado program relies heavily on the guidance of Criminal Justice Advisory Board. This board is composed of state and local law enforcement, probation, parole, corrections officials, mental health services providers and community representatives. As a pilot program of the Reentry Court Initiative, the Colorado Reentry Court receives technical assistance from the Office of Justice Programs.

The greatest success of the program so far has been the collaboration of multiple agencies to commit to this program. The major challenges cited by the program are the struggle to find an on-going source of funding once the pilot program expires and to assist offenders in finding affordable housing opportunities.

Adapted from: a U.S. Department of Justice Reentry Court Initiative Fact Sheet; Program Materials; and Minutes from a Reentry Court Initiative Cluster Meeting.

Maryland Community Criminal Justice Treatment Program

Maryland's Community Criminal Justice Treatment Program (MCCJTP) is a multi-agency collaborative effort to assists individuals with mental illness that come in contact with the local criminal justice system. The program developed from a growing concern over the number of individuals with mental illness residing in local jails. The underlying premise guiding this program is that communities must provide a continuum of care for offenders with mental illness after they are released from jail in order to prevent those individuals from continuously cycling through the system.

In order to ensure that offenders with mental illness were receiving adequate treatment and post-release services and to prevent recidivism, Maryland created the MCCJTP to bridge the gap between incarceration and release. The program is a joint federal, state and local effort and the funding is shared between the three partners. The following elements are the basis for the program: the development of local partnerships; state agency support and involvement; broad case management services; provision of enhanced services for the homeless and people with co-occurring disorders; development of a diversion program; on-going training of criminal justice and treatment professionals; and program evaluation. The MCCJTP program has been successful in developing a comprehensive system of care for offenders with mental illness through the involvement of all stakeholders.

The two most important aspects of the program that deter reentry into the criminal justice system are case management and enhanced services. Each detainee receives a case manager to guide them through the system. Case managers provide identification of candidates, screening and assessment, counseling and reentry planning, act as a criminal justice system liaison and on-going monitoring in the community. The focus on enhanced services for the homeless and individuals with co-occurring disorders assist program participants in vocational training, housing and rental assistance, substance abuse treatment, filling out paperwork and developing and committing to a treatment plan.

MCCJTP has been in operation for 8 years and the accomplishments of the program have been noted by government, treatment and criminal justice professionals and clients. The program has improved the identification and treatment of the incarcerated persons with mental illness, increased communication between mental health and criminal justice agencies, increased the coordination of in-jail and community services and decreased the disruption in local jails. In 1996 the program served 1700 individuals in 18 of 24 jurisdictions in Maryland.

Adapted from: Conly, C. (1999). Coordinating Community Services for Mentally Ill Offenders: Maryland's Community Criminal Justice Treatment Program (MCCJTP). Washington, DC: National Institute of Justice.

New York State Parole-Mental Health Initiatives

A Memorandum of Understanding (MOU) between the New York State Office of Mental Health (OMH) and the New York State Division of Parole, composed in 1986 and revised in 1994, laid the groundwork for a series of parole-mental health initiatives. The MOU: enhanced coordination around mental health evaluations for the Board of Parole; increased reentry planning; implemented mental health training for parole officers; and established a Parole-Intensive Case Management program. Various programs around the state have developed as a result of the partnership between OMH and Parole, including the following:

Pre-Release Coordinators
The provider of prison mental health services in New York State established 16 pre-release coordinator positions in each of its satellite and mental health units. The coordinators are responsible for reentry planning for inmates with serious mental illness.

Parole-Mental Health Training
OMH and Division of Parole trained 1,000 parole officers on issues surrounding serious mental illness, the mental health service system, and appropriate coordination between parole and local mental health agencies. The training is now part of parole recruit training.

NYC-LINK
The NYC-LINK is a program that provides diversion, reentry planning, and transition services to offenders with mental illness who are being released from confinement in city jails, or state or federal prisons. Case managers work with clients to develop a comprehensive reentry plan with appropriate referrals and regular meetings in reentry planning groups. Clients are then transferred to community-based Transition Management Team prior to release, who provide short-term case management services. Transition management services are provided on an intensive basis in the community for roughly two months following release. The program also provides psychotropic medications during the first 90 days of community reentry of persons with serious mental illness.

Homeless Ex-Offender Program
Working with HUD, the OMH funded 8 transitional and 28 supportive apartment beds that were made available to ex-offenders returning to the community from jails and State prisons. Case managers diverted ex-offenders from homeless shelters to these residences and provided on going supportive services.

Dedicated Parole Caseloads
Special parole caseloads were established in areas with high concentrations of parolees with mental illness. Parole and local mental health staff were cross-trained and guidelines were established between the two agencies.

A*dapted from a communication from the New York State Office of Mental Health, Forensics.*

Ohio Department of Rehabilitation and Corrections: The Ohio Plan

The State of Ohio settled a 1991 class action lawsuit (*Dunn v. Voinovich)* by signing and implementing a consent decree. This consent decree inspired a set of new initiatives in prison mental health care. The Ohio Department of Rehabilitation and Corrections (DRC) chose to develop a service system that is consistent with a community mental health model by providing a continuum of care and treatment for inmates with mental illness throughout their confinement.

The Ohio Plan emphasizes the following components in its continuum of care:

Identification and Treatment Planning: All inmates received by DRC or transferred to other institutions within the system are screened by medical and mental health staff for mental illness. Those identified with a mental illness are referred to psychiatrists or licensed psychologists ,for evaluation and treatment recommendations. Treatment planning is conducted by a multi-disciplinary team and includes the inmate.

Tracking: A computerized classification system identifies the level of mental health care provided to inmates. Before being transferred to other facilities, the inmate's level of classification is verified to ensure that care can be continued in the new facility.

Acute Care: The Oakwood Correctional Facility provides short-term intensive treatment for those who represent a risk of harm to themselves or others.

Clusters: The prison system is divided into clusters of institutions. Clusters are like catchment areas. Cluster mental health teams work collaboratively and use a multidisciplinary approach to developing a range of interventions, including outpatient and residential services. Each cluster has a treatment unit for those who require a therapeutic milieu and full range of services.

Psychiatric Outpatient Services: Mental health care and support services are offered for offenders with serious mental illness who can function in the general population.

Community Linkages: The DRC and the Department of Mental Health work together to provide community linkages for inmates with mental illness leaving prison. Community social workers assist inmates prior to release to set up appointments with mental health agencies to ensure continuity of care.

The reorganized system aims to coordinate appropriate and continuous care for inmates with mental illness.

Adapted from "Best Practices: Excellence in Corrections, (1998). Edward E. Rhine, Ed., American Correctional Association: Landham, MD and Executive Summary of the Ohio Plan.

Project Hope: Rhode Island, A System of Care Model

The goal of Project Hope is to prevent the restrictive placement for transitioning adjudicated youth with serious emotional disturbances and their families by creating a single, integrated community-based system of care. This system of care is designed to reduce recidivism by enhancing mental health service delivery and supports for transitioning youth and to increase referrals from youth incarcerated at the Rhode Island Training School to the children's behavioral health system.

The target population for Project Hope includes youth with serious emotional disturbances who are transitioning back to the community from a juvenile correctional placement who meet the following eligibility criteria:

- Must have been adjudicated
- Must either be transitioning out of or recently released from the Rhode Island Training School
- Be diagnosed with a mental health, behavioral or emotional disorder; and
- Be under age 18, unless and Individual Educational Plan is in place; which increased eligibility to age 22.

Participation in Project Hope begins while the youth is still in the custody of the Rhode Island Training school, and is triggered by the youth's anticipated release date- usually 60 to 90 days in advance of release. A clinical social worker at the school completes a referral form and discusses Project Hope with the youth. If the youth meets the eligibility criteria and expresses an interest in participating in the program, a family services coordinator from Project Hope meets with the youth to further explain the program and a home visit is scheduled to begin the assessment process.

As part of the home visit, the family services coordinator conducts a strength-based assessment and begins to explore options for services with the family. After the home visit, a Community Planning Team meeting is scheduled while the youth is still in the Training School to develop a recommended service plan. This meeting includes the Training School social worker, the assigned Project Hope service coordinator and case manager, a counselor and the youth and family.

After the youth is released, a second Community Planning Team meeting is scheduled to begin implementation of the service plan. The Project Hope family service coordinator and the case manager follow-up with the family to provide referrals for traditional and non-traditional or wraparound services and on-going case management. Youth and families typically participate in the program for 9 to 12 months.

Adapted from The Center for Mental Health Services Responses to 11 Questions About the Comprehensive Community Mental Health Services for Children and their Families Program., December 15, 2000. Substance Abuse and Mental Health Services Administration.

The Wayne County Jail-Based Treatment Program

The Wayne County (Michigan) Jail-Based Treatment Program provides in-custody and continuing aftercare treatment services for substance-abusing offenders, many of whom have co-occurring mental health disorders. The program targets felony offenders. Assessment, treatment services, discharge planning, multi-systems coordination, information sharing, and resource coordination begin while the inmate is incarcerated. A controlled release is utilized to facilitate the offender's seamless transition into aftercare treatment in the community.

Programming: In the jail portion of the program, which typically lasts 10-12 weeks, inmates receive various services, including:

- Individual therapy
- Group therapy
- Cognitive Skills and Calm Training
- Relapse prevention
- 12 Step programs
- Urine testing
- GED and adult education classes.

Case Management
Case management activities begin at enrollment and continue throughout participants' tenure in the project. Case managers work with clinical staff to assist inmates in meeting goals of their individualized treatment plans. Case managers identify and link inmates to ancillary supports and services in the community.

Aftercare Services
After completing the jail-based component, participants proceed to residential aftercare for a minimum of 60 days. Participants are expected to comply with all requirements of the treatment provider while enrolled in aftercare. Individuals with co-occurring disorders receive therapy, medication, medication monitoring, mental health case management services and joint case planning through a collaboration between the Department of Community Justice and the Detroit-Wayne County Community Mental Health Agency. Residential treatment is followed by eight weeks of outpatient treatment.

Alumni Group
The project offers alumni groups to provide a forum to discuss the day-to-day stresses encountered in the community after release from formal treatment programming. The alumni group offers opportunities for drug-free social, athletic and recreational opportunities. Continued participation in the alumni group is expected to result in earlier detection of problems that lead to relapse and deterioration.

Adapted from a document produced by the program.

References

Alexander, J., Barton, C., Gordon, D., Grotpeter, J., Hansson, K., Harrison, R., Mears, S., Mihalic, S., Parsons, B., Pugh, C., Schulman, S., Waldron, H., & Sexton, T. (1998). *Blueprints for Violence Prevention, Book Three: Functional Family Therapy.* Boulder, CO: Center for the Study and Prevention of Violence.

Altschuler, D.M., Armstrong, T.L., (1994). Intensive Aftercare for High Risk Juveniles: A Community Care Model. Program Summary. Washington, DC: US Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Barr, H. (1999). *Prisoners and Jails: Hospitals of Last Resort*. New York: The Correctional Association of New York and the Urban Justice Center.

Beck, A. (2000). *State and Federal Prisoners Returning to the Community: Findings from the Bureau of Justice Statistics.* Presented at the First Reentry Courts Initiative Cluster Meeting. Washington, DC.

Center for Mental Health Services. (1998). *1998 Inventory of Mental Health Services in Juvenile Justice Facilities, Halfway Houses and Group Homes.* Survey. Rockville, MD: U.S. Department of Health and Human Services.

Center for Substance Abuse Treatment. (1998). *Continuity of Offender Treatment for Substance Use Disorders from the Institution to Community.* G. Field. (Consensus Panel Chair) CSAT, Treatment Improvement Protocol (TIP) Series, Number 30. Washington, DC: U.S. Government Printing Office.

Cocozza, J.J., Skowyra, K.(2000).Youth with Mental Health Disorders in the Juvenile Justice System: Issues and Emerging Responses. Juvenile Justice. Volume VII, Number 1. Washington, DC: US Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Federal Task Force on Homelessness and Severe Mental Illness. (1992). *Outcasts on Main Street: Report of the Federal Task Force on Homelessness and Severe Mental Illness*. Washington, DC: Interagency Council on the Homeless.

Grisso, T., and& Barnum, R. (1998). Massachusetts Youth Screening Instrument (MAYSI): *Preliminary manual and technical Report.* Worcester, MA: University of Massachusetts Medical School.

Grisso, T., and Barnum, R. (2000). *Massachusetts Youth Screening Instrument-2 (MAYSI-2): User's manual and technical report*. Worcester, MA: University of Massachusetts Medical School.

Henggeler, S. et. al. (1998). *Blueprints for Violence Prevention. Book Six: Multisystemic Therapy*. Golden, CO: Venture Publishing.

Healey, K. M. (1999). *Case Management in the Criminal Justice System.* Washington, DC: U.S. Department of Justice, National Institute of Justice.

Hills, H. (2000). *Creating Effective Treatment Programs for Persons with Co-Occurring Disorders in the Justice System.* Delmar, NY: The National GAINS Center for People with Co-Occurring Disorders in the Justice System.

Interagency Council on the Homeless. (1994). *Priority: Home! The Federal Plan to Break the Cycle of Homelessness.* Washington, DC: U.S. Department of Housing and Urban Development.

Kamradt, B (2000). WrapAround Milwaukee: Aiding Youth with Mental Health Needs, Juvenile Justice Journal of the Office of Juvenile Justice and Delinquency Prevention. Vol. VII No. 1. U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Martin, S., Butzin, C., Saum, C., and J. Inciardi. (1999). "Three-year outcomes of therapeutic community treatment for drug-involved offenders in Delaware: from prison to work release to aftercare." *The Prison Journal*. 79(3): 294-321.

McClellan , A. and R. Dembo. (1993). *Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents.* Center for Substance Abuse Treatment, Treatment Improvement Protocol (TIP) Series, Number 3. Washington, DC: U.S. Government Printing Office.

Morrissey, J. (1999). "Integrating service delivery systems for persons with a severe mental illness." In *A Handbook for the Study of Mental Health: Social Contexts, Series and Systems.* A. Horwitz & T. Scheid (Eds.). New York City: Cambridge University Press.

National Drug Court Institute. (1999). *Reentry Drug Courts.* Washington, DC: U.S. Department of Justice.

Open Society Institute Center on Crime, Communities and Culture and the National GAINS Center for People with Co-Occurring Disorders in the Justice System. (1999). *The Courage to Change: A Guide for Communities to Create Integrated Services for People with Co-Occurring Disorders in the Justice System.* Washington, DC: The Substance Abuse and Mental Health Services Administration.

Otto, R.K., Greenstein, J.J., Johnson, M.K., and Friedman, R.M. (1992). "Prevalence of mental disorders among youth in the juvenile justice system." In *Responding to the Mental Health Needs of Youth in the Juvenile Justice System,* (Ed.) J.Cocozza. Seattle, WA: The National Coalition for the Mentally Ill in the Criminal Justice.

Peters, R. and M. Bartoi. (1997). *Screening and Assessment of Co-Occurring Disorders in the Justice System.* Delmar, NY: The National GAINS Center for People with Co-Occurring Disorders in the Justice System.

Schultz, C.S. and Mitchell-Timmons, J. (1995). *Prevalence of Mental Disorders in a Juvenile Justice Population.* Cleveland, OH: Case Western Reserve University School of Medicine, Department of Psychiatry.

Steadman, H. (1992). "Boundary Spanners: A Key Component for the Effective Interactions of the Justice and Mental Health Systems." *Law and Human Behavior*. 16(1): 75-87.

Steadman, H. and B. Veysey. (1997). *Providing Services for Jail Inmates with Mental Disorders*. Washington, DC: U.S. Department of Justice, National Institute of Justice.

Teplin, L. (2001). *Assessing Alcohol, Drug and Mental Disorders in Juvenile Detainees*. Fact Sheet. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Travis, J. (2000). *But They All Come Back*: *Rethinking Prisoner Reentry.* Research in Brief-Sentencing and Corrections: Issues for the 21st Century, Washington, DC: U.S. Department of Justice, National Institute of Justice.

U.S. Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

Virginia Policy Design Team. (1994). *Mental Health Needs of Youth in Virginia's Juvenile Detention Center*. Richmond, VA: Virginia Policy Design Team.

Wierson, M., Forehand, R.L., and Frame, C.L. (1992). "Epidemiology and the treatment of mental health problems in juvenile delinquents. *Advances in Behavior Residential Theory*. 14: 93-120.

Wood, P.N., Trupin, E., Turner, A., Vander Stoep, A., Stewart, D., (1999). The Community Transition of Incarcerated Mentally Ill Youth: An Outcome Study. Seattle, WA. Washington State Department of Social and Health Services and the University of Washington.